Wisconsin Medicaid Program
Measurement Year (MY) 2021, 1/1/21 – 12/31/21
Hospital Pay-for-Performance (P4P) Guide

Contents

Measurement Year (MY) 2021 Hospital P4P – Overview 2

Measurement Year 2021 Hospital Health Information Exchange (HIE), Withhold (PPR), and Assessment P4P Timeline 4

Data Submission and Validation Process 5

MY 2021 HIE P4P Program 6

MY 2021 Withhold P4P Program (Potentially Preventable Readmissions) 7

Goal of the PPR program 7

PPR Calculations 7

Qualifying Providers 9

Withhold and Return 9

PPR Data Report Delivery Schedule 10

HMO PPR Policy 11

Withhold PPR P4P Methodology Example 12

MY 2021 Assessment P4P Program 14

Assessment P4P Measures 15

Estimated Assessment P4P State Averages 16

Assessment P4P Measures Detail 17

Assessment P4P Methodology 18

Assessment P4P Methodology Example 19

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Measurement Year (MY) 2021 Hospital P4P – Overview

The time frame for the measurement year (MY) is from January 1, 2021 through December 31, 2021. Recent Hospital P4P measurement years are as follows:

- Measurement Year 2019: January 1, 2019 – December 31, 2019 **(completed)**
- Measurement Year 2020: January 1, 2020 – December 31, 2020 **(in progress)**
- Measurement Year 2021: January 1, 2021 – December 31, 2021

For MY 2021, the Department of Health Services (DHS) is implementing an additional P4P program, Health Information Exchange (HIE), to incentivize participation in data sharing as required by 2019 WI Act 185.

On January 1, 2018, DHS implemented a 3 percent withhold on inpatient fee-for-service claims. This withhold is applied to claims for those providers who qualify for the Potentially Preventable Readmissions (PPR) quality measure. Qualifications for this program are described in this document.

The Assessment P4P program will continue as it currently operates, as described in this document.

DHS recognizes that MY 2021 P4P program outcomes and data may be impacted by the COVID-19 response. As part of the evaluation process of the measurement year, DHS will review and analyze COVID-related impacts to identify if adjustments are needed to determine program performance.

The goal of the P4P program is to promote and recognize high quality patient care at all hospitals throughout Wisconsin. DHS believes that through high quality patient care, it will be possible to increase positive health outcomes and improve the lives of all Wisconsin residents. Therefore, this program is an integral part of the overall quality initiative at DHS. DHS encourages all hospitals to actively participate in the P4P program and to work toward fully meeting the performance targets that are set for each measure, as well as maintaining high performance in all areas, including those not covered by this program.

The purpose of this Guide is to provide an overview of the program, its components, the methodology, and the measures, to those who have an interest in the program. As new policies regarding the P4P program become active, this document will be updated to reflect the most current information. Additionally, with each new measurement year, this document will receive a full review to ensure that all information contained within is relevant to the given measurement year. Any questions related to the topics covered by this Guide or the P4P program in general should be directed to the DHS contacts listed on the previous page. Additionally, please sign up

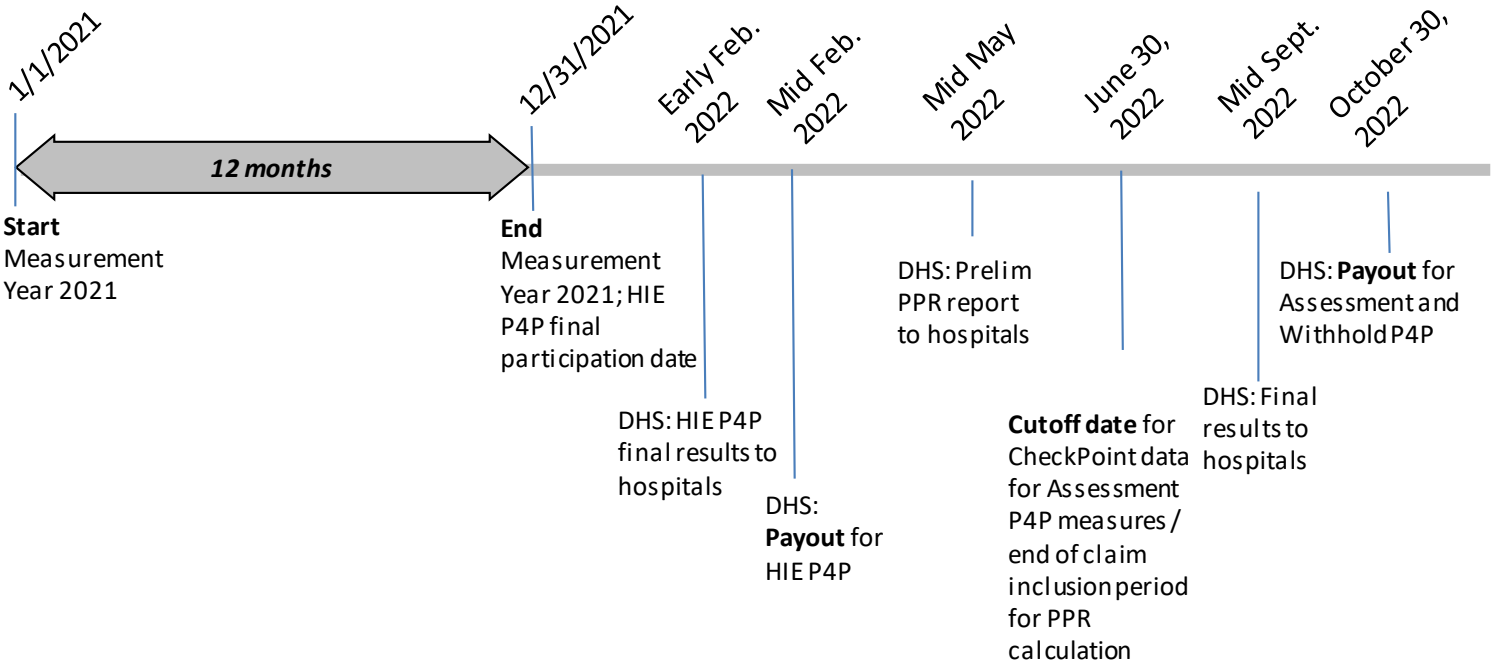
for the quality program mailing list by contacting one the DHS contact listed on the previous page and asking to be added to the list. This list will be used to keep providers up-to-date on DHS quality program developments.

The rest of this Guide is devoted to describing the Health Information Exchange (HIE), Withhold, and Assessment P4P programs in detail. This includes: a timeline for the program, an overview of the program, a description of the performance measures being used, the performance targets for each measure, and examples of the methodology that will be used to calculate the results and payments.

Measurement Year 2021

Hospital Health Information Exchange (HIE), Withhold (PPR), and Assessment P4P Timeline

MY 2021



Data Submission and Validation Process

Reviewing Preliminary Results with Hospitals

After the data submission cut-off date, DHS calculates and compiles the results and shares them with the hospitals. Hospitals are expected to review the results and respond to DHS with comments and supporting data in case there are discrepancies between the results calculated by DHS and those by the hospitals. DHS will then review the data submitted by hospitals.

MY 2021 HIE P4P Program

The HIE P4P program, required by 2019 WI Act 185, is to incentivize participation in health information data sharing to facilitate better patient care, reduced costs, and easier access to patient information. Hospital performance metrics will be based on participation in Wisconsin Statewide Health Information Network (WISHIN). WISHIN is the state-designated entity for HIE and Wisconsin Medicaid managed care contracts also require HMO participation in WISHIN.

Performance metrics will be based on a hospital's participation status in three WISHIN interface categories:

1. Admission, Discharge, and Transfer (ADT)
2. Consolidated Clinical Document Architecture (CCDA)
3. Lab/Pathology and Radiology

A hospital's participation status will be met if they are contracted with WISHIN by December 31, 2021. Each in-state hospital is eligible to receive $15,000 - $40,000 of bonus funding for each of the three interface categories for which they meet the required participation status. In order to meet the participation status for Lab/Pathology and Radiology, a hospital must meet participation status for all three interfaces (lab, pathology and radiology) to receive funding.

Payments will vary by hospital based on projected CY 2021 Medicaid funding developed through the rate setting process. These projected amounts include inpatient, outpatient, fee-for-service and HMO volume. Any new eligible hospital that does not have projected Medicaid funding amounts will receive the minimum amount of funding. Hospitals that have the lowest proportion of projected funding are eligible to receive $15,000 per interface category and the hospitals with the largest proportion are eligible to receive up to $40,000 per interface category. The minimum a hospital would receive for meeting all participation requirements would be $45,000 (3 interfaces X $15,000 per interface) and the most a hospital would receive would be $120,000 (3 interfaces X $40,000 per interface).

MY 2021 Withhold P4P Program (Potentially Preventable Readmissions)

For Measurement Year 2021, the Inpatient Withhold P4P measure is Potentially Preventable Readmissions (PPR).

Goal of the PPR program

DHS seeks to reduce PPRs in the Wisconsin Medicaid Program. Excess readmission chains relative to benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care.

Specifically, DHS aims to reduce the state-wide, fee-for-service (FFS) PPR rate by 7.5 percent for end of MY 2021. The state-wide FFS PPR rate for the performance benchmark year (Calendar Year 2019) is 6.65 percent. Note the goal rate could vary slightly due to risk adjustments to reflect acuity differences between the baseline year CY 2019 and the MY 2021. The PPR rate is calculated as follows:

PPR Rate = Initial Admissions ÷ (Initial Admissions + Only Admissions)

CY 2019 Statewide FFS PPR Rate = 2,044÷ (2,044+26,391) = **7.19%**

Goal Rate for Measurement Year 2021 = 7.19% * 92.5% = **6.65%**

See below for additional details on the Initial Admission and Only Admission terminology, benchmarking, and the measurement year.

PPR Calculations

The 3M PPR software analyzes all admissions for Medicaid FFS inpatient claims. Each admission is classified by the software as either an admission that is not associated with readmissions, an admission that resulted in one or more readmissions, or a readmission.

The 3M PPR software classifies each admission into one of the following categories:

- Only Admission (OA): A claim that is not a potentially preventable readmission and is not followed by a potentially preventable readmission (at any hospital) within a certain timeframe. DHS has selected a 30 day review window
- Initial Admission (IA): A claim that is not a potentially preventable readmission and is followed by a potentially preventable readmission (at any hospital) within 30 days
- Qualifying Admission (QA): A sum of Only Admissions and Initial Admissions. QAs represent total inpatient admissions, excluding designated potentially preventable readmissions. This value is used to determine eligibility for the PPR P4P measure, as described below.
- Readmission (RA): A claim that is a potentially preventable readmission associated with an initial admission within 30 days prior

- Exclusion: A claim that is excluded from measurement under 3M's clinically-based algorithm exclusions (example: clinically complex cases). See below for additional details on exclusions
- PPR Chain: A sequence of non-excluded inpatient discharges that occur within a 30-day window. A PPR chain consists of an Initial Admission (IA) and at least one Readmission (RA). As such, a count of Initial Admissions will be the same as a count of PPR chains.

Risk Adjustment and Benchmarking:

1. Actual IAs and benchmark IAs (readmission chains) are aggregated for each provider to determine risk adjusted readmission chain rates.
2. Readmission chain rates will be calculated using only FFS inpatient claims data. No HMO claims data will be used.
3. Benchmark IAs are risked adjusted and calculated for each provider based on the CY 2019 statewide average rate of IAs by APR-DRG and Severity of Illness combination. Further adjustments to benchmark IAs are made to account for differences in patient age and secondary mental health diagnosis. Benchmark IAs by provider are aggregated based on the provider's 2021 mix of services (based on APR-DRG and patient age) and volume.
4. Benchmark IAs are compared to actual IAs for each provider. "Excess" IAs are actual IAs exceeding benchmark IAs. Measuring provider performance based on actual vs. risk adjusted benchmark IAs (readmission chains) enables DHS to compare provider performance even when there are differences in inpatient volume and case mix.
5. Providers who are paid on a per diem basis are included in the development of statewide average rate of IAs by APR-DRG and Severity of Illness, though these providers are exempted from PPR-based incentives / penalties.

Exclusions:
As noted above, a number of services and diagnoses are excluded in the PPR software for inclusion into the classifications indicated above. Claims that are excluded will not be counted for benchmarking or performance measurement. These exclusions include:

a. Neonate admissions
b. Malignancy (cancer-related) admissions
c. Certain drug and alcohol related services (DRG 770)
d. Chronic kidney disease and dialysis
e. Additional non-event DRGs, procedure codes, and discharge status codes

A full listing of these exclusions can be found on the ForwardHealth Hospital provider page: https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/Handout1_3M_PPR_Manual.pdf.spage

Transfers:
The 3M PPR software evaluates discharge status codes to determine if the patient was transferred. In instances where an acute-care provider (including critical access hospitals) transfers a recipient to another acute-care provider, the original hospital admission is reclassified

as a Transfer Admission (TA) and the receiving hospital is classified as either: only admission (if no readmission occurs post-discharge) or initial admission (if a readmission follows the discharge). Stays classified as TA are not included in the numerator or denominator when calculating a provider's readmission rate. The TA consideration is designed to recognize that the original hospital cannot treat the patient but the receiving hospital can. As such, the receiving hospital takes responsibility for the patient's care including discharge planning activities. For example, if a premature baby is delivered at a critical access hospital and then transferred to a hospital with a neonatal intensive care unit, the receiving hospital is responsible for appropriate discharge and follow-up coordination, not the original critical access hospital. Transfer admissions are identified by discharge status codes: 02, 05, 82, 85.

In instances where an acute-care provider transfers a recipient to a non-acute care provider (e.g. skilled nursing facility), the receiving facility is classified as a Non-Event Transfer (NE) and the original facility retains responsibility should the recipient be readmitted after leaving the non-acute facility within the readmission time window. The NE consideration is designed to recognize that the original hospital level of care is no longer needed for the patient but the discharge planning crafted by the acute-care hospital requires continued care/monitoring at another facility rather than the recipient being discharge home. Acute-care providers should work closely with non-acute facilities to ensure potentially preventable readmissions are avoided.

Qualifying Providers

1. Type of Provider:
    a. Providers paid on a per-diem basis are excluded from the PPR measures, including the claims withhold. For 2021 this includes psychiatric hospitals, rehabilitation hospitals, and long term acute care (LTAC) providers. Providers paid on a DRG basis are included.
2. Qualifying Admissions
    a. Providers with 25 or fewer qualifying admissions per year, averaged over two prior years, are excluded from the PPR P4P program, including claim payment withholds. Qualifying admissions are the sum of Initial Admissions and Only Admissions, as described above. Providers with more than 25 qualifying admissions averaged over two prior years are included in the PPR measures.
3. Location
    a. All in-state providers are included in the PPR measure and, assuming they meet the above two qualifications, the PPR Withhold P4P program.
    b. Out of state providers are included in the PPR measure and, assuming they meet the two qualifications described above and have border status, the P4P program.
    c. Out of state, non-border providers are included in the PPR measure only, not the claim payment withhold.

Withhold and Return

A withhold of 3 percent of inpatient, fee-for-service claims will be applied for the Withhold P4P. This will apply to claims with dates of service from 1/1/2021 to 12/31/2021.[1]

[1] Specifically, the "last" or "to" date of service that represents the discharge date.

Withheld funds will be returned to hospitals consistent with the incentive/penalty methodology described below. This payout will occur based on performance for MY 21, consistent with the model provided later in this document.

PPR Data Report Delivery Schedule

In 2018, hospitals started receiving quarterly PDF summary reports, a list of PPR chains and related data, and a data dashboard.

These reports and PPR chain lists can be accessed on the ForwardHealth portal page. This access can be granted by your hospital's portal administrator. **If you do not know who this is, or if they are unable to grant you access, please contact the portal help desk at 866-908-1363**. DHS will contact hospitals to obtain a designated staff person for data dashboard access.

The table below indicates anticipated data delivery dates

Measurement period	Working data available on approximately:	Preliminary annual report available on:	Final annual report available on:
2021			
1/1 – 3/31	5/15/2021	N/A	N/A
4/1 – 6/30	8/15/2021	N/A	N/A
7/1 – 9/30	11/15/2021	N/A	N/A
10/1 – 12/31	2/15/2022	N/A	N/A
2022			
1/1 – 3/31	5/15/2022	**5/15/2022 (data for MY2021)**	N/A
4/1 – 6/30	8/15/2022	N/A	N/A
7/1 – 9/30	11/15/2022	N/A	**9/15/2022 (data for MY2021)**
10/1 – 12/31	2/15/2023	N/A	N/A
2023			
1/1 – 3/31	5/15/2023	**5/15/2023 (data for MY2022)**	N/A
4/1 – 6/30	8/15/2023	N/A	N/A
7/1 – 9/30	11/15/2023	N/A	**9/15/2023 (data for MY2022)**
10/1 – 12/31	2/15/2024	N/A	N/A

HMO PPR Policy

Starting in 2018, Medicaid HMOs have the opportunity to participate in a PPR incentive program. HMOs are judged based on their members' readmissions at hospitals to which they are admitted. HMO performance is based on HMO claims only, and will not include fee-for-service claims. HMOs will be eligible for incentive dollars based on their PPR performance, and will be required to share a portion of those dollars with the providers with whom they partner to reduce PPRs. The 2021 HMO P4P guide with PPR information will be posted prior to December 31, 2020 at the following website:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage.

Public Reporting of PPR Results

In order to increase transparency and drive improvement efforts, DHS seeks to provide the public with additional information related to hospital PPR performance, based on outcomes for MY 2021. The Department will continue to engage with hospital stakeholders to determine the best manner to present this data.

Incentive/Penalty Methodology

1. Benchmark: the benchmark year will be Calendar Year 2019, January 1, 2019 – December 31, 2019. A hospital's FFS claims data for this year will be the basis for the benchmark against which a hospital is assessed – that is, the Benchmark (or "expected") Initial Admissions.

2. Withhold Return and Incentives: providers will receive their withhold dollars and incentive payments commensurate with how their individual MY 2021 count of Initial Admissions compares to their Benchmark Initial Admissions which is based on the CY 2019 statewide data and risk adjusted to reflect the provider's MY 2021 acuity and volume.

    a. Providers will receive no more than 10 percent of their MY 2021 FFS inpatient claim payments as an incentive, and will be penalized no more than the 3 percent that the withhold represents.

3. Excluded Providers: providers that do not qualify for the PPR measure, as indicated above, are not subject to the withhold and will not be eligible for incentive payments.

See the next pages for a demonstration of the Incentive/Penalty Methodology.

Withhold PPR P4P Methodology Example

Legend for Tables	
P4P = Pay for Performance, PPR = Potentially Preventable Readmission	
Column 1	Hospital Name
Column 2	$ withheld = 3% of FFS Inpatient claims payments
Column 3	PPR $ = Total inpatient claims dollars related to any PPR initial or re admission
Column 4	Initial Admissions = # of total chains a provider had in MY
Column 5	Benchmark Initial Admissions = .925 * Initial Admission benchmark from 3M PPR software
Column 6	Chains Above Benchmark = Column 4 – Column 5 if Column 4 > Column 5, 0 otherwise
Column 7	Average PPR $ Per Chain = Column 3 / Column 4
Column 8	Amount Penalized = Column 7 * Column 6 or Column 2, if Column 7 * Column 6 is greater than Column 2
Column 9	Withhold Return = Column 2 – Column 8
Column 10	Hospital Name (Same as Column 1)
Column 11	Withhold Remaining for Incentive Distribution = Column 2 – Column 9
Column 12	Chains Below Benchmark = Column 5 – Column 4, if Column 5 > Column 4, 0 Otherwise
Column 13	Incentive Scaling Factor = Average of (Column 7) * Column 12
Column 14	Proportion of PPR $ for Incentive Payment = Column 13 / Sum(Column 13)
Column 15	Incentive Payment = Column 14 * Sum(Column 11)
Column 16	Total Payment = Column 9 + Column 15

1	2	3	4	5	6	7	8	9
Hospital	**Withhold $***	**PPR $**	**Initial Admissions** (MY 21 performance)	**Benchmark Initial Admissions** (CY 19)	**Chains Above Benchmark** (4 – 5, 0 if negative)	**Average $ PPR / Chain** (3 / 4)	**Amount Penalized** (6 * 7, but no more than column 2 value)	**Withhold Return** (2 – 8)
A	$25,000	$80,000	27	22	5	$2,962.96	$14,814.80	$10,185.20
B	$110,000	$220,000	56	26	30	$3,928.57	$110,000	$0.00
C	$50,000	$35,000	8	15	0	$4,375.00	0	$50,000.00
D	$160,000	$230,000	18	20	0	$12,777.78	0	$160,000.00
E	$80,000	$64,000	20	16	4	$3,200.00	12,800	$67,200
Total	$425,000	$629,000	129	99	39		$137,614.80	$287,385.20

10	11	12	13	14	15	16
Hospital	**Withhold Remaining for Redistribution** (sum of 2 – sum of 9)	**Chains Below Benchmark** (5 – 4, or 0 if negative)	**Incentive Scaling Factor** (Statewide Average of Column 7 * 12)	**Proportion of PPR $ for Incentive Payment** (13 / Sum of Column 13)	**Incentive Payment**** (14 * Total Column 11)	**Total Payment** (9 + 15)
A		0	0	0		$10,185.20
B		0	0	0		$0
C		7	$34,131.37	.7778	$100,000.00	$150,000
D		2	$9,751.82	.2222	$37,614.80 *	$197,614.80
E		0	0	0		$67,200
Total	$137,614.80	9	$43,883.19	1.00	$137,614.80	$425,000

*This Provider would receive the remaining funds in this example since Provider C reached the 10% claims payment cap

**This model is simplified to pay out all funds in one round. The actual model will likely require multiple rounds of incentive distribution to ensure all penalty/incentive funds are paid out while maintaining the 10% claims payment cap.

MY 2021 Assessment P4P Program

The Assessment P4P program **only** applies to inpatient admissions. The Assessment P4P provides for payments to acute care, children's, and rehabilitation hospitals located in Wisconsin. Critical access hospitals are not included in the Assessment P4P program because they already receive cost-based reimbursement. Psychiatric hospitals are not included because they are paid under a different reimbursement methodology in the State Plan.

The program is funded by $5 million which is set aside from the hospital assessment levy for P4P by the State. The hospital assessment raises funds from hospitals that are then expended on this P4P program as well as access payments and other supplemental payments. The P4P funds are then split among the measures used during the MY, described in detail on the next several pages.

The Department determines the payment amounts and recipients for each measure separately. The more hospitals that meet the performance targets, the less money distributed to each individual hospital. The opposite is also true; if very few hospitals meet the targets for one or more of the measures, the payouts for those measures will be higher for those hospitals that meet the targets. With the understanding that payouts to hospitals by measure may vary, the entire $5 million will be paid out regardless of how many or how few hospitals meet the performance targets. The State does not keep any funds from the Assessment P4P program.

Payment will be made by October 30 following the conclusion of the measurement year.

The three measures and allocation of money for the MY 2021 are as follows:

Measure	MY 2021	Share Division
Pay-For-Performance		
1. **Perinatal Measures**: 2 Sub-measures as follows: a) Cesarean Section b) Newborn Screening Turnaround Time	**$ 2 million** Target = statewide average	100% = 2 of 2 75% = 1 of 2
2. Patient Experience of Care	**$1.5 million** Target = statewide average	100% = 3 of 10
3. Central-line Associated Blood Stream Infection (CLABSI)	**$1.5 million** Target = statewide average	100%= statewide avg.

Assessment P4P Measures

This chart shows the three assessment measures for the measurement year, their individual components, where the data is sourced from, and what the measurement period is for each.

Measure	Data Source	Measurement Period
1. Perinatal Measures a. Cesarean Section b. Newborn Screening Turnaround Time	CheckPoint	1/1/2021 to 12/31/2021*
2. HCAHPS a. Patients Ranked Hospital High b. Definitely Recommend Hospital c. Doctors Always Communicated Well d. Nurses Always Communicated Well e. Patients Always Received Help As Soon as They Wanted f. Staff Always Explained Medications g. Understood Care When They Left h. Always Quiet at Night i. Room Was Always Clean j. Staff Provided Discharge Instructions	CheckPoint	7/1/2020 to 6/30/2021*
3. Central Line Blood Stream Infections- CLABSI	CheckPoint	1/1/2021 to 12/31/2021*

**Dates reflect the data scheduled to be available on CheckPoint on 6/30/2022. These dates are subject to change if the data for these timeframes is not available to WHA.*

Estimated Assessment P4P State Averages

This table provides estimates of what the statewide averages may be for each of the three assessment measures, and their component measures in the case of the perinatal measures and HCAHPS. As indicated on page 4, P4P results will be based on performance relative to average performance during this measurement year rather than prior year averages – a hospital must equal or outperform those measurement year averages to receive payment for a given Assessment P4P measure. The averages below are estimates to serve as a target for planning purposes. Actual averages *will* vary from those listed below.

Measure	Numerator	Denominator	Estimated State Average (as of this writing)	Positive or Negative Measure
Perinatal Measures				
Cesarean Section (PC-02)	Not available from CheckPoint	Not available from CheckPoint	22%	Negative**
Newborn Screening Turnaround Time	Not available from CheckPoint	Not available from CheckPoint	98%	Positive
HCAHPS (Patient Experience of Care)		**Statewide Average (n=66 hospitals)**		All Sub-measures are positive.
Patients Ranked Hospital High		78%		
Definitely Recommend Hospital		76%		
Doctors Always Communicated Well		84%		
Nurses always communicated well		84%		
Patients always received help as soon as they wanted		74%		
Staff always explained medications		70%		
Understood Care When They Left		57%		
Always quiet at night		66%		
Room was always clean		80%		
Staff Provided Discharge Instructions		90%		
Central Line Associated Blood Stream Infections (CLABSI):	Numerator data not available from Checkpoint	Denominator data not available from Checkpoint	0.57	Negative**

*= including all hospitals with > 0 in the denominator
**= Negative means that a hospital must score equal to or lower than the published average.

Assessment P4P Measures Detail

This page provides a more detailed description of the Assessment P4P program measures.

1. Perinatal Measures ($2 million):

There are two components to this measure, as shown below:

a. Cesarean Section (PC-02)
b. Newborn Screening Turnaround Time

Both components for this measure are reported through the WHA (Wisconsin Hospital Association) CheckPoint website. For this measure the goal is to score better than the published statewide average. A hospital can earn a 100% "full share" of the $2 million by equaling or outperforming the statewide average on both of the sub-measures, or a 75% "partial share" of the $2 million by equaling or outperforming the statewide average on one of the sub-measures.

2. Patient Experience of Care Survey (HCAHPS) ($1.5 million):

This measure is made up of 27 survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) that cover the entire hospitalization experience. These are grouped into the ten components of the measure. The data is reported to CheckPoint. For this measure the goal is to score equal to or greater than the published statewide average. A hospital can earn a 100% "full share" of the $1.5 million by scoring at or above the statewide average on at least three of the ten sub-measures.

3. Central Line Associated Blood Stream Infections (CLABSI) ($1.5 million):

The CLABSI surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf) within the National Healthcare Safety Network (NHSN) provides the definitions and reporting structure for this measure. This measure uses a standardized infection ratio to compare a hospital's results against the state average. Data for this measure is reported to CheckPoint. For this measure the goal is to score equal to or less than the published statewide average. A hospital can earn a 100% "full share" of the $1.5 million by equaling or outperforming the statewide average for this measure.

Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating CLABSI surveillance in monthly reporting plans, entering monthly numerators and denominators (device days and patient days) in all eligible units, and reporting only primary BSIs as CLABSIs.
- The SIR is only calculated when the number of predicted CLABSIs is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf
- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
- Contact Alistair Carr, Senior Healthcare Data Analyst at the Wisconsin Hospital Association, at 608-274-1820 or acarr@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

Assessment P4P Methodology

The Department determines the payment amounts and recipients for each measure separately. The Department calculates the "full share" payment amount for a measure by dividing the budget for the measure by the sum of ("partial" and "full") shares earned by hospitals; the "partial share" payment amount is the "full share" payment amount multiplied by the "partial share" percentage. For example, if, for the Perinatal Measure, 25 hospitals qualify for "full shares" and 20 hospitals qualify for 75% "partial shares," the sum of the shares is (25 +(0.75 x 20)) = 40, so the 25 hospitals each earn $50,000 ($2 million /40) while the 20 hospitals each earn $37,500 ($50,000 x 0.75).

Please see the following page for another detailed example of the methodology.

Assessment P4P Methodology Example

This chart shows an example of the Assessment P4P methodology, using the perinatal measures.

Step	Example

• Set the **targets** for each of the performance-based Birth Measures:
  • Cesarean Section
  • Newborn Screening Turnaround Time
	Assume beginning with **70** hospitals in scope for this measure.

• At the end of the MY, determine the number of hospitals **reporting** all required perinatal measures. Hospitals reporting all required perinatal measures will be eligible to participate in the perinatal P4P fund distribution.	**Assume 50** out of 70 hospitals report all required perinatal measures. Only these 50 hospitals are eligible to participate in the perinatal P4P incentive.

• Determine how many hospitals from Step 2 **meet** exactly:
  • Zero perinatal targets = not eligible for perinatal P4P money
  • 1 perinatal target= 75% share
  • 2 perinatal targets= 100% share
	Assume: of the 50 hospitals reporting all perinatal measures:
	• 20 hospitals meet 0 targets
	• 10 hospitals meet 1 target
	• 20 hospitals meet 2 targets

• Calculate individual hospital **points** and total points for hospitals meeting:
  • Zero perinatal targets = $0 from perinatal P4P = 0 points each
  • Exactly 1 target = 75% of incentive = 0.75 points each
  • 2 targets = 100% of incentive = 1 point each
	• 20 hospitals get 0 points = $0 for perinatal; total points for this group = 20*0 = 0;
	• 10 hospitals get 0.75 points; total points = 10*0.75 = 7.5;
	• 20 hospitals get 1 point; total points = 20*1 = 20.
	
	Total points for all hospitals
	= (20*0) + (10*0.75) + (20*1) = 27.5 points

• Determine percent **share** in incentive money for hospitals earning 75% of the incentive, and those earning 100% of the incentive. Calculate the incentive money for each hospital.	• **Share** of the 10 hospitals that get 0.75 points each, in the total perinatal $ = $\frac{7.5 \text{ points}}{27.5 \text{ points}} = 27.27\%$ of $2 million = $545, 454. Divided equally among the 10 hospitals, each gets $54,545. • **Share** of the 20 hospitals that get 1 point each = $\frac{20}{27.5} = 72.72\%$ of $2 million = $1,454,546. Divided equally among the 20 hospitals, each gets $72,727.